APPEAL NO. 022049
FILED SEPTEMBER 18, 2002

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing (CCH) was held on July 17, 2002. The hearing officer determined that the appellant/cross-respondent (claimant) reached maximum medical improvement (MMI) on May 27, 2000, with a 10% impairment rating (IR), in accordance with the report of the designated doctor, which was not contrary to the great weight of the other medical evidence.

The claimant appeals, arguing that he was not at MMI on the designated doctor's certified date because he subsequently had surgery. He argues that the hearing officer analyzed the MMI issue under an erroneous standard that could constitute prohibited rulemaking that would limit the effect of the 1989 Act. The claimant argues that his IR was incorrectly calculated by reference to a version of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association (AMA Guides) that did not apply. He argues facts to support his contention that the designated doctor's report is against the great weight of the contrary medical evidence. The claimant asks that his treating doctor's report with the higher IR be adopted. The respondent/cross-appellant (carrier) responds that the "active consideration" analysis of surgery at MMI is moot, since the designated doctor actually considered the surgical aspect and did not change his opinion. The carrier argues that it was not appropriate in this case to seek clarification from the designated doctor and says that it objected to this "at an earlier stage of the proceeding". The carrier points out that if the Texas Workers' Compensation Commission (Commission) is prevented from rulemaking, then the consequence is that in the case of spinal surgery the only way MMI can be altered is through the processes set forth in Sections 408.104 and 410.307, and that neither circumstance would apply to the facts of this case. The carrier responds that the hearing officer properly accorded presumptive weight to the designated doctor's report. The carrier conditionally appeals the findings of the hearing officer that the carrier's chosen doctor did not properly apply the AMA Guides and that the claimant had disability for the time period between the certified date of MMI up until statutory MMI. The carrier seeks review of these findings only if the decision is not affirmed. There is no response to this appeal.

DECISION

We reverse and remand.

FACTS

In this case the date of injury was _____, when the claimant tripped as he was carrying a 50-pound box of drywall and he twisted while trying to catch himself. The claimant was treated conservatively with therapy and pain injections, and by spring

2000 was reported as having some emotional and psychological problems related to his pain. The carrier denied requested psychological treatment.

There are medical records from his treating doctor (a chiropractor) in April 2000 indicating that surgery was being discussed with the claimant, and the next month precertification was sought for discography. The claimant was also referred to an orthopedic surgeon by his treating doctor for evaluation of a herniated lumbar disc. The initial request for approval of the discogram was refused. Likewise, a request for additional physical therapy was refused by the carrier in April 2000.

The carrier's chosen doctor examined the claimant and initially found that he had a 7% IR, with an MMI date of January 20, 2000, and then the doctor disallowed part of the IR for the effects of a prior injury to arrive at a 4% IR. The treating doctor disagreed with this, and a designated doctor examined the claimant on May 27, 2000. The designated doctor was erroneously instructed by the Commission that MMI was not in issue, but it was, and the designated doctor was later asked to reconsider his MMI date in light of the controversy. The designated doctor amended the MMI date to the date of his examination to May 27, 2000. His evaluation was performed in accordance with the third edition, second printing of the AMA Guides. The designated doctor assigned a 10% impairment for the claimant's back injury, and his report does not indicate that he considered any recommendations that were made by the treating or consulting doctors for surgery. Dispute Resolution Information System notes reflect that the claimant called the Commission on August 7, 2000, stating that he still disputed the MMI date because testing to see if he needed surgery was being denied by the carrier. The claimant was informed that he could go through medical dispute resolution and that he would need "medical" to dispute the designated doctor's report.

A July 2000 EMG was reported as normal. After the orthopedic surgeon renewed a request for a discogram in late August 2000, it was approved, and showed abnormalities at two levels. However, the orthopedic surgeon reported on September 26, 2000, that he believed these abnormal discs were degenerative and not a result of the compensable injury. He stated his further opinion that surgery was not required at this point. There is no evidence in the record, however, of a dispute by the carrier over the nature of the compensable injury.

A request for an electronic muscle stimulator was denied by the carrier in October 2000. The claimant testified that his treating doctor then sent him to a neurosurgeon who recommended a repeat discogram in November 2000 to better assess the claimant's condition. However, a CT myelogram was approved and performed late that month and the neurosurgeon found no obvious evidence of nerve compression.

By March 15, 2001, the neurosurgeon, noting the contradictory objective testing and the claimant's continued unrelieved pain, recommended another pain injection and then final assessment of the claimant's options in another month. An MRI was

approved by the carrier on April 3, 2001. The stipulated date of "statutory" MMI was April 20, 2001.

Spinal surgery was recommended at the end of July 2001, approved through the second opinion process, and then performed on September 26, 2001. The carrier approved the purchase of a hospital bed and a raised toilet seat for the claimant in October 2001.

The operative report was forwarded by a benefit review officer (BRO) to the designated doctor in February 2002; there is no indication that any other reports showing the course of treatment and evaluation between May 2000 and the surgery were also given to the designated doctor for his evaluation. The question posed to him was:

Please inform us if this changes your opinion regarding [MMI] and [IR] or whether your assessment was done right at the time you saw the claimant.

He was not asked to consider whether a reexamination would be appropriate. The designated doctor responded by affirming the correctness of his original IR at the time it was done "based upon the records reviewed and the evaluation performed." The designated doctor also stated that it was based upon the definition of MMI "which implies that there will be no significant change in the impairment over the next year" and that this definition applied in this case. He noted that he did not have records at that time indicating that surgery was being recommended. He further commented that the Fourth Edition of the AMA Guides made no provision for a change of IR for spinal surgery.

The treating doctor rendered two IR reports, one under the Third Edition of the AMA Guides, and one under the Fourth Edition. The IRs were 16% and 15%, respectively.

WHETHER THE REPORT OF THE DESIGNATED DOCTOR WAS CONTRARY TO THE GREAT WEIGHT OF OTHER MEDICAL EVIDENCE

Under the facts of this case, we agree that the hearing officer erred by giving presumptive weight to the report of the designated doctor. First of all, the question posed to the doctor by the BRO about whether his earlier report was "done right" at the time it was written was irrelevant to resolution of the dispute in this case. The designated doctor should have been asked whether a reexamination would be appropriate. Second, we cannot minimize the comment by the designated doctor about the Fourth Edition of the AMA Guides, which did not apply in this case (pursuant to Tex. W.C. Comm'n, 28 TEX. ADMIN. CODE § 130.1 (Rule 130.1), as an insignificant comment; a fair reading of that letter makes it clear that his mistake about the version of the AMA Guides is the basis for not considering an additional IR for surgery.

Third, the designated doctor applied his own definition of MMI, rather than the one set forth in Section 401.011(30), which does not impose a one-year improvement criterion. But an evaluation even under his own definition is rendered suspect by the fact that he did not have complete medical records in May 2000 or at the time of the requested clarification, and the designated doctor was deprived of considering the surgery as the culmination of a complicated medical history and ongoing evaluation. Even setting aside the effect of surgery on the IR, a review of all of the records leading up to surgery was plainly relevant to whether the date of MMI had been prematurely assigned by the designated doctor. Lastly, we agree that the great weight of contrary medical evidence in this case is against the claimant having achieved MMI on May 27, 2000, as opposed to the date of statutory MMI.

We cannot agree that it was inappropriate to contact the designated doctor regarding additional medical information which at the very least bore relevance to the accuracy of a May 27, 2000, MMI date. We accordingly reverse the determination that the designated doctor's May 27, 2000, MMI certification was entitled to presumptive weight, as the great weight of contrary medical evidence indicates that MMI may not have been reached medically until after the statutory date of MMI, which would make MMI in this case the "statutory date" defined by Section 401.011(30)(B). We remand for further development and consideration of the evidence. Because the response of the designated doctor indicated error over applying the correct version of the AMA Guides, and that he felt constrained from considering an amendment to the IR because of this error, the IR issue is not as clear, and on remand the hearing officer should reconsider seeking clarification from the designated doctor in accordance with this decision and then weighing any response in accordance with Section 408.125. The period found for disability should be adjusted to correspond with the new date of MMI found by the hearing officer.

THE CARRIER'S APPEAL

Whether or not it complied with the AMA Guides, the report of the carrier's chosen doctor that MMI was reached on January 20, 2000, is not supported by the medical evidence in this case. The report by the carrier's chosen doctor further was in error by deducting his assessment of impairment from a previous injury. As the Appeals Panel stated in Texas Workers' Compensation Commission Appeal No. 93889, decided November 17, 1993, Section 408.084 makes clear that it is the Commission, not a doctor assessing impairment, who will determine the extent to which any contributing injury is one for which an employee "has already been compensated" through a request for contribution.

On the matter of inability to work after May 27, 2000, the claimant testified that he had not been able to work from that date to the CCH because of his back pain. Medical records for the period bear out his active treatment for intractable pain. A claimant's testimony alone, when believed, is sufficient to establish that an injury has caused disability. Gee v. Liberty Mutual Fire Insurance Company, 765 S.W.2d 394 (Tex. 1989). The record supports the hearing officer's determinations of these two issues.

As stated above, the hearing officer should reconsider whether further contact with the designated doctor is appropriate. If so, complete medical records should be furnished. If not, then the hearing officer should adopt a report of another doctor on MMI and/or impairment.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Commission's Division of Hearings, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* Texas Workers' Compensation Commission Appeal No. 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **ILLINOIS NATIONAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE COMPANY
800 BRAZOS, SUITE 750, COMMODORE 1
AUSTIN, TEXAS 78701.

_____
Susan M. Kelley
Appeals Judge

CONCUR:

_____
Thomas A. Knapp
Appeals Judge

_____
Michael B. McShane
Appeals Judge